POC # 2 Licensure "A" penalty

PRINTED: 05/22/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7201	A. BUILDING _____ B. WING _____	05/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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N 000	Initial Comments During the annual Licensure and complaint survey #27230, #27636, #27265, #28092, #27500, #28839 conducted on May 7, 2012, through May 15, 2012, the facility was cited a Type "A" penalty for failure to be administered in a manner to ensure an effective system was in place to ensure the residents' were free from abuse for four residents (#1, #2, #4) failed to investigate allegations of abuse for three residents (#1, #16, #11), and failed to supervise to prevent accidents for six residents (#18, #2, #4, #14, #19, #26) of twenty-seven residents reviewed which placed resident #1, #2, #4, #11, #14, #16, #18, #19, and #26 in an environment which was detrimental to health, safety and welfare.	N 000	**F226 483.13(c) Develop/ Implement Abuse/Neglect, etc. Policies.** 1) Resident # 1 On 5/16/12 the Administrator conducted a late investigation on the allegation made by resident # 1 that the employee's spouse blocked him in room, touched his arm, and threatened him. -5/27/12-Inservice given by Administrator to employees' spouse.	5/29/12
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. This Rule is not met as evidenced by: Based on medical record review, review of facility	N 401		

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N 000			-Witness statement was added to the abuse investigation form. A one on one in-service was given to the employee's spouse by the Administrator on 5/17/12. -Employee's spouse attended an in-service on abuse and neglect on 5/27/12. -On 5/29/12, the DON investigated an allegation of abuse, using the new forms approved on 5/27/12, including witness statements and documented interviews. Exhibit # 2 Exhibit #35 On 05/16/2012 the Administrator conducted an investigation regarding resident #1's allegation of an employee's spouse making threatening remarks to him. -Witness statement was obtained and added to the exhibit. Exhibit #3-revised	5/29/12

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N000		N000	5/27/12-Inservice given by Administrator to employees' spouse. Exhibit# 2 On 5/16/12, the Administrator conducted a late investigation regarding resident #1 allegation that another employee's spouse was making threatening remarks to him. Employee no longer employed. Late investigation revised and a witness statement added. Revised Exhibit # 3 Reported to staff allegations of another resident having grabbed him on July 7, 2011. This was investigated by previous DON and noted in resident's medical record on July 7, 2011. Attached are the progress notes of the investigation. Exhibit # 12	5/29/12

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N000		N000	Resident #16 On 2/19/12, MDS Coordinator entered a note in medical records noting inappropriate feeding by family member. MDS Coordinator intervened and replaced family member who was feeding resident inappropriately at the time of noted occurrence. Exhibit # 13 Abuse investigation policies have been reviewed and revised on 5/27/2012 by the DON, and approved by Medical Director, Administrator, and QA Committee 5/27/12. On 5/27/12, DON revised Incident reporting process to capture abuse incidents on the facility's Incident Report form to improve tracking and ensure investigation. Inservices given to all RN's,	5/27/12

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N000		N000	LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 5 <u>Resident # 11</u> On 05/16/12 the DON began the process for counseling LPN #3 concerning her approach to Resident #11 for inappropriate nursing actions related to cleaning up feces from floor. Employee resigned May 17, 2012 before actual counseling was done. This incident was reported to the Board of	5/29/12

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N000		N000	Nursing by DON on 05/29/2012. Exhibit # 8 Abuse investigation policies have been reviewed and revised on 5/27/2012 by the DON, and approved by Medical Director, Administrator, and QA Committee 5/27/12. On 5/27/12, DON revised Incident reporting process to capture abuse incidents on the facility's Incident Report form to improve tracking and ensure investigation. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to	5/29/12

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N000		N000	work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #5 Upon notification that there were six employees with no abuse checks conducted, on 5/16/12, the Office Manager began obtaining abuse registry checks which were completed on 5/28/12. The documentation and tracking of employee attendance at mandatory in-services i.e. abuse attendance and other in-services were evaluated by the DON and a new process was implemented on 5/29/12. Each employee will have an attendance record with the mandatory in-services typed on the attendance record form with attendance date to be recorded when in-service is attended. The DON will conduct mandatory in-services at least twice a year to ensure an opportunity for employee	5/29/12

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N000		N000	attendance. DON/Office Manager will oversee inservices and report to QA/PI. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until inservices are complete. Exhibit # 16 2) The DON reviewed the deficiencies stated in the 2567 to. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on – Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents	5/29/12

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N000		N000	with Seizures, and Behavior Management. In-services were given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 15 Exhibit #9 The following policies or procedures have been changed to address these deficient practices: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Assessment on Admission and Quarterly -Abuse Investigation -Resident Rights – Guidelines for all Nursing Procedures All in-services given to all RN's,		5/29/12

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W000		W000	LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until in-services are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #10 Teachable moments/in-services for licensed staff were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints i.e. Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in	5/29/12

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W000		W000	attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #11 On 5/27/12, the Medical Director evaluated and assessed all resident with psychoactive medication and/or residents with behavior diagnoses. The evaluation was documented in the resident's Medical Record on 05/27/12. All resident's care plans were reviewed and revised for appropriate approaches/interventions for abuse and seclusion and resident rights by the MDS Coordinator. This process was begun 5/16/12 and completed on 5/29/12. All other residents were assessed for S/S of abuse by MDS Coordinator/ DON/ADON, completed 5/29/2012.	5/29/12

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N000		N000	On 5/29/11 the Administrator changed the company conducting background checks to a new instant National Criminal Background Check-Sentrylink. The changes were made to expedite receiving results of requested background check and National Sex offenders' registry. On 5/27 and 5/28 all employees files were checked for abuse, and other required checks by the Office Manager.	5/29/12

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N 401	Continued From page 1 policies, observation, and interview, the facility failed to be administered in a manner to ensure four (#1, #2, #4, #11) residents were free from abuse, failed to investigate allegations of abuse, failed to provide staff in-services on abuse, failed to provide supervision to ensure eleven (#1, #2, #3, #4, #5, #11, #14, #18, #19, #16 and #26) residents were provided a safe environment, and failed to ensure one resident was provided mental health services (#5) of twenty-seven residents reviewed. The findings included: Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator's office, confirmed no allegations of abuse had been investigated since December 23, 2010, and the facility's policy related to "Abuse Investigation" had not been implemented. Interview with the Administrator on May 15, 2012, at 3:15 a.m., in the Administrator's office, confirmed the facility failed to provide in-services on Abuse to the direct care staff in 2011 and none to date in 2012. C/O #27636 #27230 #27265 #28092	N 401	**F 490 483.75 Effective Administration/Resident Well-being** 1) Upon notification by Surveyor of immediate jeopardy concerning abuse, failure to investigate allegations of abuse, failure to provide staff in-services on abuse, failure to provide supervision, a safe environment and failure to provide resident #5 mental health services, the Administrator and DON began working on in-services, reviewing and revising policies and procedure and evaluating the process for conducting abuse investigation and ensuring residents have mental health consults, this was started on 5/16/12 and continuing.	5/29/12
N 415	1200-8-6-.04(10) Administration (10) When licensure is applicable for a particular job, verification of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Documentation that references were verified shall be on file. Documentation that all appropriate abuse registries have been checked shall be on	N 415	On 5/26/12 the Administrator confirmed the contract agreement with Healthcare Consultant to assist with addressing compliance of the deficiencies sited on May 14 and 15 by the Health Surveyors.	

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N401		N401	On 05/28/12 the Abuse Investigation / Incident and Accident/ Investigating and Reporting Policy / Restraint Management Policy was reviewed and revised by the Health Care Consultant . The Health Care Consultant inserviced these policies with the DON, Administrator and Medical Director emphasizing the importance of elimination of the use of seclusion, reporting abuse, investigation, using the Resident Abuse Investigation Report Form, timely investigations and capturing all incidents. Exhibit #29 The DON implemented a Behavior Assessment and Monitoring Program which includes a consultation with Geriopysch Practitioner when needed by residents. Effective following approval by the Medical Director and QA Committee on 5/27/2012. Exhibit #6	5/29/12

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N401		N401	All residents admitted to the facility will have a Social Services Assessment / History according to facility policy. Exhibit #7 The facility will maintain 100% compliance of checking abuse registry on all new employees will be completed. Exhibit # 30 DON will conduct mandatory in-services at least twice a year to ensure an opportunity for employee attendance. Effective 5/29/2012. DON implemented a new Side Rail Assessment to be conducted on all new admissions and Quarterly thereafter. A Falls Prevention Program called The Falling Leaf Program	5/29/12

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N401		N401	was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to evaluating and identifying appropriate interventions. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Beginning 5/22/12 the Physical Therapist began screening residents with falls. Use of Restraint policy was developed by DON and approved by Medical Director and QA Committee 5/27/12. No restraints can be applied without approval of DON/ Medical Director.	5/29/12

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N401		N401	Exhibit # 10 After being informed by surveyor that CNA #12 had transported Resident #21 down the hallway from shower room, in a Hoyer Lift, the DON conducted a teachable moment with CNA #12 and other staff working that day teaching that residents must not be transported in the hallway when residents are in the Hoyer lift. The Hoyer lift policy was reviewed with all staff working on the 6-2pm and 2-10pm shifts by the DON. Inservices were then given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to	

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N401		N401	address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on – Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. Inservices were then given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI President of Laurelbrook School, will oversee Laurelbrook Nursing Home Administrator to ensure compliance and that the quality of care will be provided. Effective 5/29/2012.	5/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7201	A. BUILDING _____ B. WING _____	05/15/2012

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N 415	Continued From page 2 file. Adequate medical screenings to exclude communicable disease shall be required of each employee. This Rule is not met as evidenced by: Based on review of personnel files and interview, the facility failed to ensure documentation of Hepatitis B vaccination for three of five personnel files and failed to ensure Tuberculosis screening for two of five personnel files reviewed. The findings included: Review of the facility's personnel files revealed three of five personnel files contained no evidence of Hepatitis B vaccination or offer of vaccination, and two of five personnel files reviewed contained no verification of ever having a Tuberculosis screening. Interview with the Business Office Manager on May 15, 2012, at 1:25 p.m., in the Business office, confirmed the facility failed to perform adequate communicable disease screenings.	N 415	**F 490 483.75 Effective Administration/Resident Well-being** 1) Upon notification by Surveyor of immediate jeopardy concerning abuse, failure to investigate allegations of abuse, failure to provide staff in-services on abuse, failure to provide supervision, a safe environment and failure to provide resident #5 mental health services, the Administrator and DON began working on in-services, reviewing and revising policies and procedure and evaluating the process for conducting abuse investigation and ensuring residents have mental health consults, this was started on 5/16/12 and continuing.	5/28/12
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to provide supervision to prevent accidents for seven (#18, #2, #3, #4, #14, #19,	N 424	On 5/26/12 the Administrator confirmed the contract agreement with Healthcare Consultant to assist with addressing compliance of the deficiencies sited on May 14 and 15 by the Health Surveyors.	

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	TN7201	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2012

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N415		N415	On 05/28/12 the Abuse Investigation / Incident and Accident/ Investigating and Reporting Policy / Restraint Management Policy was reviewed and revised by the Health Care Consultant . The Health Care Consultant inserviced these policies with the DON, Administrator and Medical Director emphasizing the importance of elimination of the use of seclusion, reporting abuse, investigation, using the Resident Abuse Investigation Report Form, timely investigations and capturing all incidents. Exhibit #29 The DON implemented a Behavior Assessment and Monitoring Program which includes a consultation with Geriopysch Practitioner when needed by residents. Effective following approval by the Medical Director and QA Committee on 5/27/2012. Exhibit #6	5/29/12

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N415		N415	All residents admitted to the facility will have a Social Services Assessment / History according to facility policy. Exhibit #7 The facility will maintain 100% compliance of checking abuse registry on all new employees will be completed. Exhibit # 30 DON will conduct mandatory in-services at least twice a year to ensure an opportunity for employee attendance. Effective 5/29/2012. DON implemented a new Side Rail Assessment to be conducted on all new admissions and Quarterly thereafter. A Falls Prevention Program called The Falling Leaf Program	5/29/12

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N415		N415	was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to evaluating and identifying appropriate interventions. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Beginning 5/22/12 the Physical Therapist began screening residents with falls. Use of Restraint policy was developed by DON and approved by Medical Director and QA Committee 5/27/12. No restraints can be applied without approval of DON/ Medical Director.	5/29/12

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W415		W415	Exhibit # 10 After being informed by surveyor that CNA #12 had transported Resident #21 down the hallway from shower room, in a Hoyer Lift, the DON conducted a teachable moment with CNA #12 and other staff working that day teaching that residents must not be transported in the hallway when residents are in the Hoyer lift. The Hoyer lift policy was reviewed with all staff working on the 6-2pm and 2-10pm shifts by the DON. Inservices were then given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-	6/29/12

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N415		N415	services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on – Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. Inservices were then given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI President of Laurelbrook School, will oversee Laurelbrook Nursing Home Administrator to ensure compliance and that the quality of care will be provided. Effective 5/29/2012.	5/29/12

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N 415	Continued From page 2 file. Adequate medical screenings to exclude communicable disease shall be required of each employee. This Rule is not met as evidenced by: Based on review of personnel files and interview, the facility failed to ensure documentation of Hepatitis B vaccination for three of five personnel files and failed to ensure Tuberculosis screening for two of five personnel files reviewed. The findings included: Review of the facility's personnel files revealed three of five personnel files contained no evidence of Hepatitis B vaccination or offer of vaccination, and two of five personnel files reviewed contained no verification of ever having a Tuberculosis screening. Interview with the Business Office Manager on May 15, 2012, at 1:25 p.m., in the Business office, confirmed the facility failed to perform adequate communicable disease screenings.	N 415		
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to provide supervision to prevent accidents for seven (#18, #2, #3, #4, #14, #19,	N 424	**F 406 483.45 (a) Provides /Obtain Specialized Rehab Services** 1) Resident #5 Discharged from facility on 2/5/11.	5/29/12

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N 424	Continued From page 3 #26) residents of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the nursing assessment dated March 1, 2012, revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily. Medical record review of a facility care plan, last reviewed on March 1, 2012, revealed "...side rails up times 2..." Medical record review of a nurse's progress note dated August 10, 2011, revealed "...resident crawled between foot board and bed rail...observed on floor..." Medical record review of a facility investigation dated August 10, 2011, revealed "...got out of bed & (and) fell...devices in use...side rails...2..." Medical record review of a nurse's progress note dated September 25, 2011, revealed "...resident climbed between bedrail and footboard...observed sitting on the floor..." Medical record review of a facility investigation dated September 25, 2011, revealed "...devices in use...side rails ...2..." Observations on May 14, 2012, at 1:00 p.m., and	N 424	On 5/27/12 the DON revised and developed new Behavior Assessment and Monitoring Policies to address residents identified as having problematic behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints, and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12. Exhibit # 19 Exhibit # 10 In-services were conducted on revised Behavior Management Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues conducted by RN/BSN. RN,	5/29/12

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N 424	Continued From page 4 May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally. Interview with Director of Nursing (DON) on May 15, 2012, at 7:50 a.m., at the nurses' station, confirmed the resident "possibly fell climbing out of the bed" and confirmed placing the resident in bed with side rails up is "not the best option...we may need another plan." Resident #2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia. Medical record review of the admission nursing assessment dated November 4, 2012, revealed the resident was severely cognitively impaired, had a history of wandering, and required limited staff assistance with Activities of Daily Living (ADLs). Review of a statement provided by the LPN (Licensed Practical Nurse) assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed "...resident #2 lying on floor in front of toilet...jerking motions in all four extremities... (LPN) had to get between them(resident #2 and resident #3) with force to stop resident #3 from kicking...resident #3 tried to hit me (LPN) and was cursing at me...assisted resident #2 up and out of bathroom...EMS (Emergency Medical Service) called ...dgtr(daughter) (#2's daughter) notified...lacerations and abrasions noted around right eye...left ear had blood on it..." Medical record review during the investigation revealed resident #2 also had a history of falls.	N 424	LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The Administrator and the DON reviewed the Gerio psych contract to ensure every other week visits could be provided timely to address residents with impaired cognition, problematic behaviors or mental illness. This was confirmed on 5/18/12 by the Administrator. <u>Resident #4</u> The Abuse Investigation policies ie; <u>Reporting Abuse to Facility Management; Resident to Resident</u>	5/29/12

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N 424	Continued From page 5 Medical record review of an incomplete facility investigation dated January 2, 2011, sustained a skin tear from a fall. No details of the fall or new interventions were documented. Medical record review of the care plan dated February 21, 2012, revealed an entry dated January 12, 2011, revealed resident tried to crawl in bed with another resident and fell..." Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Medical record review of a Nurse's Note dated February 29, 2012, at 4:00 p.m.revealed "...Resident was in geri-chair and managed to tip it over on it's side with resident still in it..." Continued review of the February 29, 2012 Nurse's Notes revealed an entry at 4:20 p.m. documenting " Resident again tipped over in geri-chair..." The resident was assessed and assisted back to the geri-chair. No new interventions were documented. Medical record review of a facility investigation dated March 1, 2012, revealed an investigation of the 4:20 p.m. fall, noting the resident sustained a "...skin tear to the left elbow and a contusion to te left side of head..." The intervention was to "...ambulate the resident for 15 min (minutes) Q (every) shift." No additional interventions to prevent falls were implemented. Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed the facility failed to ensure	N 424	Altercation; Abuse Investigations; Behavior Assessment and Monitoring have been reviewed and revised on 5/27/2012 by the DON and approved by the Medical Director, Administrator and QA Committee on 5/27/12. Inservices conducted 5/27/12-5/30/12, for all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #24 The Abuse Investigation policy was inserviced with the Administrator, DON and Medical Director on 5/27/12 by the Healthcare Consultant emphasizing the importance of recording abuse allegation,	5/29/12

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N 424	Continued From page 6 resident #2's safety. Review of a facility investigation dated February 5, 2011, revealed at 9:45 a.m. "...(#4) was sleeping in...room when another resident (#5) went into his room and started hitting...with a cane." Interview with the DON, outside the Administrator's office, on May 8, 2012 at 2:00 p.m., confirmed that no behavior management plan was documented and no additional interventions were documented, for either resident, both with known behaviors, and more should have been done to ensure resident #4's safety. Interview with the NHA (Nursing Home Administrator) May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed the resident to resident abuse occurred and resident #4 sustained a fractured left ankle as a result of the assault. Resident #3 was admitted to the facility on October 13, 2009, with diagnoses including Vascular Dementia, Hypertension and history of a Cerebro-vascular Accident (CVA/stroke). Medical record review of the admission nursing assessment dated July 27, 2010, revealed no behaviors exhibited by the resident and no cognitive deficits were documented on the comprehensive assessment. Review of a statement provided by the DON (Director of Nursing) dated December 22, 2010, revealed " ...Resident (#3) stays in his room and does not come out ...has a history of hitting people who wander into his room ...One other	N 424	investigating and reporting in a timely manner. 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on – Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. The following policies or procedures have been changed to address this deficiency practice: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Evaluation on Admission and Quarterly -Abuse Investigation -Resident Rights – guidelines for all Nursing Procedures	5/29/12

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N 424	Continued From page 7 incident in Oct 2010." No investigation or documentation related to the October 2010 incident could be produced by the facility.. Review of a statement provided by the LPN assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed, resident #2 wandered into a shared bathroom, not his own, and was found " ...(resident #2) lying on floor in front of toilet ...jerking motions in all four extremities ...(LPN)had to get between them with force to stop resident #3 from kicking ...resident #3 tried to hit me (LPN) and was cursing at me ...assisted resident #2 up and out of bathroom ...EMS called ...dgtr (#2's daughter) notified ...lacerations and abrasions noted around right eye ...left ear had blood on it ..." Review of a consultation by the Mobile Crisis Response Team dated December 6, 2010, revealed " ...client (resident #3) stated ...assaulted the resident who came into room ...would not leave ...struck (resident #2) today because resident #3 can't rely on staff to get other people out of his room ...he pays the rent on room and others shouldn't be allowed in ..." Mobile Crisis concluded resident #3 was " ...not appropriate for involuntary committal." Resident #3 was transferred to a psychiatric unit for a "...higher level of care..." Resident #4 was admitted to the facility on October 25, 2010, with diagnoses including Depression, Schizophrenia, Generalized Weakness, and history of Cerebro-vascular Accident. Medical record review of resident #4's nursing assessment dated May 10, 2012, revealed the resident was severely cognitively impaired and	N 424	RN, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10 Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints i.e. Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management Inservices were conducted 5/27/12-5/30/12 for all RN's,	5/29/12

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N 424	Continued From page 8 required limited to extensive staff assistance for activities of daily living. Interview with the NHA (Nursing Home Administrator) May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed the abuse and the facility failed to protect resident #4 from abuse which resulted in a fractured left ankle. Resident #14 was re-admitted to the facility on January 31, 2011, with diagnoses including Personality Disorder, Dementia with Behavior Disorder, and Spinal Stenosis. Medical record review of a Nurse's Note dated July 8, 2011, revealed " ...Pt (patient) fell out of her w/c (wheelchair) very small mark mid forehead ..." Review of a facility investigation of the fall dated July 9, 2011, revealed an intervention of "...resident must not be left unattended in w/c." Medical record review of a Nurse's Note dated August 5, 2011, revealed " ...resident tumbled out of her w/c at 5:33 PM ..." Review of an incomplete facility investigation dated August 6, 2011, revealed no details related to the incident and the only intervention documented was "...resident to bed after lunch." Medical record review of a Nurse's Note dated August 25, 2011, revealed "...was found lying on floor of dining room next to w/c where she was sitting for dinner...skin abrasion to right...hip area ..." Review of a facility investigation dated August 25, 2011, revealed the only new intervention was	N 424	LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 11 On 5/27/12 the Medical Director made rounds, assessed and evaluated all residents with psychoactive medications or residents with behavior diagnoses. This evaluation was also documented in the Medical Record on 5/27/12. DON/ADON/MDS Coordinator assessed all other residents to ensure appropriate services were being provided. There were no residents observed needing	5/29/12

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N 424	Continued From page 9 "...place in bed after meals." Medical record review of a Nurse's Note dated December 25, 2011, revealed "...1000 am resident found laying semi-prone on floor of lobby ...assistance back to w/c...egg sized lump noted in hairline top of R (right) head..." No investigation was completed by the facility regarding the incident and no new fall interventions were implemented. Medical record review of a Care Plan update dated February 1, 2012, revealed "...resident left unattended in w/c in room and fell out ..." Medical record review of the Nurse's Notes for February 1, 2012, revealed "...unwitnessed fall...resident's room..." Review of a facility investigation dated February 2, 2012, revealed a previous intervention not to leave the resident unattended in w/c had not been followed and no new interventions were implemented. Medical record review of the resident's nursing assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and was unrestrained. Continued nursing assessment review revealed the resident had not sustained a fall since the previous nursing assessment on November 10, 2011. Medical record review of a Physical Therapy Fall Risk Assessment dated February 5, 2012, revealed "...Ambulation screen...Max (maximum)Assist + 1-2...for all ambulation, transfers and balance."	N 424	additional services. This process began on 5/15/2012, completed on 5/27/12. The care plans were reviewed and revised by MDS Coordinator to include appropriate services. This process began on 5/15/2012, completed on 5/29/12. MDS Coordinator reviewed all other residents care plans to ensure appropriate services were care planned. This process started 5/15/12, completed 5/29/12.	

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N 424	Continued From page 10 Medical record review of a Nurse's Note dated May 8, 2012, revealed, " ...resident was in circle area...when...fell on floor..." No investigation of the fall was completed and no new interventions were implemented. Interview with the DON (Director of Nursing) in the front office, on May 15, 2012, at 9:15 a.m., confirmed the investigations noted above were incomplete and the resident continued to experience falls, with no documentation of new interventions to reduce falls risk and keep the resident free of injuries related to falls. Resident #19 was admitted to the facility on October 22, 2010, with diagnoses including Diabetes Mellitus type 2, Chronic Catatonia, Dehydration, and Venous Thrombosis. Medical record review of the nursing assessment, dated March 3, 2012, revealed the resident was moderately impaired with cognitive skills and required extensive assistance with activities of daily living, toileting and bathing. Further review of the medical record revealed the resident suffered falls on the following dates: June 28, 2011, December 22, 2011, and January 7, 2012. Medical record review of the Resident's Care Plan, dated May 14, 2012, revealed an intervention dated February 7, 2011, "...clip alarm on at all times..." Medical record review of a nurse's note, dated June 28, 2011, at 1:48 p.m., revealed "...at 1:15 p.m., resident fell out of...chair in the hallway ...was asleep and tumbled onto the floor, causing a marble sized bump to the forehead, slightly right of the middle...no other signs of pain or discomfort was noted..."	N 424		

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N 424	Continued From page 11 Review of facility documentation, dated June 28, 2011, at 1:15 p.m., revealed "...monitors/alarms: none..." Interview with the Director of Nursing (DON), on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the clip alarm was not on the resident at the time of the fall on June 28, 2011. Review of the resident's Care Plan, dated November 11, 2011,revealed "...2 person assistance at all times...maxi lift with all transfers...chair alarm on at all times..." Medical record review of a nurse's note, for resident #19, dated December 22, 2011, at 7:30 a.m., revealed "...resident in bath room in shower chair. Certified Nurse Assistant (CNA) observed resident fall sideways out of the shower chair, landing on the right side. Resident was assessed for injuries, small contusion noted to right side of forehead. No other injuries noted. Neuro checks started..." Review of facility documentation, dated December 22, 2011, at 7:20 a.m., revealed "...CNA stated to nurse that resident was in the bathroom in the shower chair... CNA observed resident fall sideways out of shower chair landing on right side...CNA stated that the shower chair did not have a seat belt...". Continued review of the facility documentation revealed "...shower chair seat belt repaired by maintenance..." Interview with CNA #11, on May 15, 2012, at 11:30 a.m., in the shower room, the CNA stated "I was giving another resident a bath and the resident was in the shower room to use the bathroom...the resident leaned forward and fell	N 424		

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N 424	Continued From page 12 out of the shower chair to the right side...the resident did not have a seat belt in use for the shower chair and the belt was not on shower chair..." Telephone Interview with Licensed Practical Nurse (LPN) #5, on May 15, 2012, at 10:30 a.m., revealed the LPN was notified by CNA #11 regarding the resident falling out of the shower chair. Further interview revealed "...the CNA told me the resident slipped on the floor and I don't remember if the straps were on the shower chair..." Interview with the Director of Nursing (DON) and the Care Plan Coordinator, on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the resident did not have a seat belt in use with the shower chair. Further interview confirmed the shower chair did not have safety belts in place, no documentation of the use of the chair alarm and the resident was left unattended. Continued interview with the Care Plan Coordinator and the DON revealed the maintenance department did not have any documentation regarding the repair of the shower chair. Resident # 26 was admitted to the facility on July 28, 2003, with diagnoses of Essential Hypertension, Macular Degeneration, Cerebral Vascular Accident, Senile Dementia, Chronic Kidney Disease, and Osteoarthritis. Medical record review of the nursing assessment, dated April 26, 2012, revealed the resident had moderate impairment of cognitive skills and highly impaired vision. Medical record review of a Nursing Progress Note, dated August 4, 2011, at 2:41 p.m.,	N 424		

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N 424	Continued From page 13 revealed "...res (resident) fell out of bed landed on the floor L (left) side ...hematoma forehead...skin tear left thumb...transfer to hospital..." Review of facility documentation, dated August 4, 2011, at 2:15 p.m., revealed "...investigation revealed faulty side rail...Update: repair side rail immediately...8/4/11 side rail repaired..." Observation on May 15, 2012, at 11:00 a.m., in the dining hall, revealed the resident sitting in a Geri-chair asleep and with a clip alarm in use. Interview with Director of Nursing (DON) and the Care Plan Coordinator, on May 15, 2012, at 12:30 p.m., in the nurse's station, confirmed the faulty side rail caused the resident to fall on August 4, 2011. Further interview with the Care Plan Coordinator confirmed the facility failed to investigate the cause of the faulty side rail, what was fixed on the side rail or a descriptive assessment of the incident. C/O #27230 #27636	N 424		
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on review of the Performance Improvement Committee attendance records, facility investigation reviews, facility policy	N 601		

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N 415	Continued From page 2 file. Adequate medical screenings to exclude communicable disease shall be required of each employee. This Rule is not met as evidenced by: Based on review of personnel files and interview, the facility failed to ensure documentation of Hepatitis B vaccination for three of five personnel files and failed to ensure Tuberculosis screening for two of five personnel files reviewed. The findings included: Review of the facility's personnel files revealed three of five personnel files contained no evidence of Hepatitis B vaccination or offer of vaccination, and two of five personnel files reviewed contained no verification of ever having a Tuberculosis screening. Interview with the Business Office Manager on May 15, 2012, at 1:25 p.m., in the Business office, confirmed the facility failed to perform adequate communicable disease screenings.	N 415		
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to provide supervision to prevent accidents for seven (#18, #2, #3, #4, #14, #19,	N 424	**F323 483.25(h) Free of accident hazards/supervision/devices.** 1) After being informed of the facilities failure to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives	5/29/12

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N 415	Continued From page 2 file. Adequate medical screenings to exclude communicable disease shall be required of each employee. This Rule is not met as evidenced by: Based on review of personnel files and interview, the facility failed to ensure documentation of Hepatitis B vaccination for three of five personnel files and failed to ensure Tuberculosis screening for two of five personnel files reviewed. The findings included: Review of the facility's personnel files revealed three of five personnel files contained no evidence of Hepatitis B vaccination or offer of vaccination, and two of five personnel files reviewed contained no verification of ever having a Tuberculosis screening. Interview with the Business Office Manager on May 15, 2012, at 1:25 p.m., in the Business office, confirmed the facility failed to perform adequate communicable disease screenings.	N 415	adequate supervision and assistance devices to prevent accidents, the following was put in place: <u>Resident # 5</u> Resident #5 discharged on 2/5/11. On 5/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address residents identified as having problematic behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12.	5/29/12
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to provide supervision to prevent accidents for seven (#18, #2, #3, #4, #14, #19,	N 424		

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N 424	Continued From page 3 #26) residents of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the nursing assessment dated March 1, 2012, revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily. Medical record review of a facility care plan, last reviewed on March 1, 2012, revealed "...side rails up times 2..." Medical record review of a nurse's progress note dated August 10, 2011, revealed "...resident crawled between foot board and bed rail...observed on floor..." Medical record review of a facility investigation dated August 10, 2011, revealed "...got out of bed & (and) fell...devices in use...side rails...2..." Medical record review of a nurse's progress note dated September 25, 2011, revealed "...resident climbed between bedrail and footboard...observed sitting on the floor..." Medical record review of a facility investigation dated September 25, 2011, revealed "...devices in use...side rails ...2..." Observations on May 14, 2012, at 1:00 p.m., and	N 424	In-services were conducted on revised Behavior Management Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues that address residents not responding satisfactorily to treatments on 5/28/12 & 5/29/12. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. <u>Resident # 4</u> The resident was treated at the hospital following incident and returned to the facility on 2/5/2011.	5/29/12

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N 424	Continued From page 4 May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally. Interview with Director of Nursing (DON) on May 15, 2012, at 7:50 a.m., at the nurses' station, confirmed the resident "possibly fell climbing out of the bed" and confirmed placing the resident in bed with side rails up is "not the best option...we may need another plan." Resident #2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia. Medical record review of the admission nursing assessment dated November 4, 2012, revealed the resident was severely cognitively impaired, had a history of wandering, and required limited staff assistance with Activities of Daily Living (ADLs). Review of a statement provided by the LPN (Licensed Practical Nurse) assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed "...resident #2 lying on floor in front of toilet...jerking motions in all four extremities... (LPN) had to get between them(resident #2 and resident #3) with force to stop resident #3 from kicking...resident #3 tried to hit me (LPN) and was cursing at me...assisted resident #2 up and out of bathroom...EMS (Emergency Medical Service) called ...dgtr(daughter) (#2's daughter) notified...lacerations and abrasions noted around right eye...left ear had blood on it..." Medical record review during the investigation revealed resident #2 also had a history of falls.	N 424	On 05/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address problematic resident behaviors that need psychiatric consultation and behavior management. These policies include the following: Behavior Assessment and Monitoring; Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behavior or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12. Inservices given 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are	5/24/12

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N 424	Continued From page 5 Medical record review of an incomplete facility investigation dated January 2, 2011, sustained a skin tear from a fall. No details of the fall or new interventions were documented. Medical record review of the care plan dated February 21, 2012, revealed an entry dated January 12, 2011, revealed resident tried to crawl in bed with another resident and fell..." Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Medical record review of a Nurse's Note dated February 29, 2012, at 4:00 p.m.revealed "...Resident was in geri-chair and managed to tip it over on it's side with resident still in it..." Continued review of the February 29, 2012 Nurse's Notes revealed an entry at 4:20 p.m. documenting " Resident again tipped over in geri-chair..." The resident was assessed and assisted back to the geri-chair. No new interventions were documented. Medical record review of a facility investigation dated March 1, 2012, revealed an investigation of the 4:20 p.m. fall, noting the resident sustained a "...skin tear to the left elbow and a contusion to te left side of head..." The intervention was to "...ambulate the resident for 15 min (minutes) Q (every) shift." No additional interventions to prevent falls were implemented. Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed the facility failed to ensure	N 424	complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 19 Resident # 18 On 05/15/2012 the DON implemented a new Side Rail Assessment to be conducted on all new admissions and quarterly thereafter. This form was approved by the Medical Director and QA Committee on 5/27/12. On 5/17/12 Resident # 18 was evaluated by DON for 1/4 side rails and these rails were applied on 5/17/12. Resident was placed on a new facility bed that allowed staff to place bed in low position.	5/29/12

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N 424	Continued From page 6 resident #2's safety. Review of a facility investigation dated February 5, 2011, revealed at 9:45 a.m. "...(#4) was sleeping in...room when another resident (#5) went into his room and started hitting...with a cane." Interview with the DON, outside the Administrator's office, on May 8, 2012 at 2:00 p.m., confirmed that no behavior management plan was documented and no additional interventions were documented, for either resident, both with known behaviors, and more should have been done to ensure resident #4's safety. Interview with the NHA (Nursing Home Administrator) May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed the resident to resident abuse occurred and resident #4 sustained a fractured left ankle as a result of the assault. Resident #3 was admitted to the facility on October 13, 2009, with diagnoses including Vascular Dementia, Hypertension and history of a Cerebro-vascular Accident (CVA/stroke). Medical record review of the admission nursing assessment dated July 27, 2010, revealed no behaviors exhibited by the resident and no cognitive deficits were documented on the comprehensive assessment. Review of a statement provided by the DON (Director of Nursing) dated December 22, 2010, revealed " ...Resident (#3) stays in his room and does not come out ...has a history of hitting people who wander into his room ...One other	N 424	Use of Restraint policy was developed by DON and approved by the Medical Director and QA Committee on 5/27/12. No restraints can be applied without approval of DON/ Medical Director. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. <u>Resident #3 & #2</u> Resident # 3 is no longer a resident at the facility. The Abuse Investigation and Incident and Accident, Investigating and Reporting policies were reviewed and	5/29/12

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N 424	Continued From page 7 incident in Oct 2010." No investigation or documentation related to the October 2010 incident could be produced by the facility.. Review of a statement provided by the LPN assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed, resident #2 wandered into a shared bathroom, not his own, and was found " ...(resident #2) lying on floor in front of toilet ...jerking motions in all four extremities ...(LPN)had to get between them with force to stop resident #3 from kicking ...resident #3 tried to hit me (LPN) and was cursing at me ...assisted resident #2 up and out of bathroom ...EMS called ...dgtr (#2's daughter) notified ...lacerations and abrasions noted around right eye ...left ear had blood on it ..." Review of a consultation by the Mobile Crisis Response Team dated December 6, 2010, revealed " ...client (resident #3) stated ...assaulted the resident who came into room ...would not leave ...struck (resident #2) today because resident #3 can't rely on staff to get other people out of his room ...he pays the rent on room and others shouldn't be allowed in ..." Mobile Crisis concluded resident #3 was " ...not appropriate for involuntary committal." Resident #3 was transferred to a psychiatric unit for a "...higher level of care..." Resident #4 was admitted to the facility on October 25, 2010, with diagnoses including Depression, Schizophrenia, Generalized Weakness, and history of Cerebro-vascular Accident. Medical record review of resident #4's nursing assessment dated May 10, 2012, revealed the resident was severely cognitively impaired and	N 424	revised by the DON and Healthcare Consultant on 5/27/12. The Healthcare Consultant inserviced these policies with the DON, Administrator and Medical Director on 5/28/12 emphasizing the importance of timely investigations and capturing all incidents. Inservices given on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. . Exhibit # 20 <u>Resident # 2, #14, #19 , #26</u> A Falls Prevention Program called The Falling Leaf	5/29/12

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	TN7201	A. BUILDING _____ B. WING _____	05/15/2012

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N 424	Continued From page 8 required limited to extensive staff assistance for activities of daily living. Interview with the NHA (Nursing Home Administrator) May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed the abuse and the facility failed to protect resident #4 from abuse which resulted in a fractured left ankle. Resident #14 was re-admitted to the facility on January 31, 2011, with diagnoses including Personality Disorder, Dementia with Behavior Disorder, and Spinal Stenosis. Medical record review of a Nurse's Note dated July 8, 2011, revealed " ...Pt (patient) fell out of her w/c (wheelchair) very small mark mid forehead ..." Review of a facility investigation of the fall dated July 9, 2011, revealed an intervention of "...resident must not be left unattended in w/c." Medical record review of a Nurse's Note dated August 5, 2011, revealed " ...resident tumbled out of her w/c at 5:33 PM ..." Review of an incomplete facility investigation dated August 6, 2011, revealed no details related to the incident and the only intervention documented was "...resident to bed after lunch." Medical record review of a Nurse's Note dated August 25, 2011, revealed "...was found lying on floor of dining room next to w/c where she was sitting for dinner...skin abrasion to right...hip area ..." Review of a facility investigation dated August 25, 2011, revealed the only new intervention was	N 424	Program was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to evaluating and identifying appropriate interventions. New forms and revised process for investigating falls have been developed and implemented 5/28/12. Fall checklist, post fall Nursing Assessment, post Fall Investigation, Occurrence Investigation Statement were approved by the DON, Administration and Medical Director on 5/28/12. Beginning 5/28/12 the Physical Therapist began screening residents with falls. The revised post Fall Investigation Form has possible Preventative Measures and suggested interventions that can aid	5/29/12

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N 424	Continued From page 9 "...place in bed after meals." Medical record review of a Nurse's Note dated December 25, 2011, revealed "...1000 am resident found laying semi-prone on floor of lobby ...assistance back to w/c...egg sized lump noted in hairline top of R (right) head..." No investigation was completed by the facility regarding the incident and no new fall interventions were implemented. Medical record review of a Care Plan update dated February 1, 2012, revealed "...resident left unattended in w/c in room and fell out ..." Medical record review of the Nurse's Notes for February 1, 2012, revealed "...unwitnessed fall...resident's room..." Review of a facility investigation dated February 2, 2012, revealed a previous intervention not to leave the resident unattended in w/c had not been followed and no new interventions were implemented. Medical record review of the resident's nursing assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and was unrestrained. Continued nursing assessment review revealed the resident had not sustained a fall since the previous nursing assessment on November 10, 2011. Medical record review of a Physical Therapy Fall Risk Assessment dated February 5, 2012, revealed "...Ambulation screen...Max (maximum)Assist + 1-2...for all ambulation, transfers and balance."	N 424	licensed staff with implementing appropriate interventions. Also Fall Prevention and Potential Interventions and Strategies for Reducing the Risk for Falls were posted at the Nursing Station as a resource for selection of interventions if a fall occurs. This was done 5/29/12 by DON. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Inservices given; 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in	5/29/12

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N 424	Continued From page 10 Medical record review of a Nurse's Note dated May 8, 2012, revealed, " ...resident was in circle area...when...fell on floor..." No investigation of the fall was completed and no new interventions were implemented. Interview with the DON (Director of Nursing) in the front office, on May 15, 2012, at 9:15 a.m., confirmed the investigations noted above were incomplete and the resident continued to experience falls, with no documentation of new interventions to reduce falls risk and keep the resident free of injuries related to falls. Resident #19 was admitted to the facility on October 22, 2010, with diagnoses including Diabetes Mellitus type 2, Chronic Catatonia, Dehydration, and Venous Thrombosis. Medical record review of the nursing assessment, dated March 3, 2012, revealed the resident was moderately impaired with cognitive skills and required extensive assistance with activities of daily living, toileting and bathing. Further review of the medical record revealed the resident suffered falls on the following dates: June 28, 2011, December 22, 2011, and January 7, 2012. Medical record review of the Resident's Care Plan, dated May 14, 2012, revealed an intervention dated February 7, 2011, "...clip alarm on at all times..." Medical record review of a nurse's note, dated June 28, 2011, at 1:48 p.m., revealed "...at 1:15 p.m., resident fell out of...chair in the hallway ...was asleep and tumbled onto the floor, causing a marble sized bump to the forehead, slightly right of the middle...no other signs of pain or discomfort was noted..."	N 424	attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The newly created falls checklist has a notation to remind the staff to notify PT of falls. The Falls Prevention and Potential Interventions were placed at the nurse's station 5/28/12. New forms and revised process for investigating falls, and the the revised post falls investigation forms were inserviced to RN's, LPN's, and CNA's 5/28/12-5/30/12 by DON and RN/BSN. The DON is responsible for the overall Falls Prevention Program, effective 5/29/2012.	5/29/12

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N 424	Continued From page 11 Review of facility documentation, dated June 28, 2011, at 1:15 p.m., revealed "...monitors/alarms: none..." Interview with the Director of Nursing (DON), on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the clip alarm was not on the resident at the time of the fall on June 28, 2011. Review of the resident's Care Plan, dated November 11, 2011,revealed "...2 person assistance at all times...maxi lift with all transfers...chair alarm on at all times..." Medical record review of a nurse's note, for resident #19, dated December 22, 2011, at 7:30 a.m., revealed "...resident in bath room in shower chair. Certified Nurse Assistant (CNA) observed resident fall sideways out of the shower chair, landing on the right side. Resident was assessed for injuries, small contusion noted to right side of forehead. No other injuries noted. Neuro checks started..." Review of facility documentation, dated December 22, 2011, at 7:20 a.m., revealed "...CNA stated to nurse that resident was in the bathroom in the shower chair... CNA observed resident fall sideways out of shower chair landing on right side...CNA stated that the shower chair did not have a seat belt...". Continued review of the facility documentation revealed "...shower chair seat belt repaired by maintenance..." Interview with CNA #11, on May 15, 2012, at 11:30 a.m., in the shower room, the CNA stated "I was giving another resident a bath and the resident was in the shower room to use the bathroom...the resident leaned forward and fell	N 424	The Accident and Incidents Clinical Protocol policy for conducting Neuro checks following incidents where residents may have suffered head injury during the fall or an un-witnessed fall, was revised to call the Physician and obtain orders for frequency of Neuro checks. All residents experiencing falls will be monitored for 72 hours including Neuro checks as ordered by physician. DON or designee will monitor this process effective 5/16/12. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI.	5/29/12

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N 424	Continued From page 12 out of the shower chair to the right side...the resident did not have a seat belt in use for the shower chair and the belt was not on shower chair..." Telephone Interview with Licensed Practical Nurse (LPN) #5, on May 15, 2012, at 10:30 a.m., revealed the LPN was notified by CNA #11 regarding the resident falling out of the shower chair. Further interview revealed "...the CNA told me the resident slipped on the floor and I don't remember if the straps were on the shower chair..." Interview with the Director of Nursing (DON) and the Care Plan Coordinator, on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the resident did not have a seat belt in use with the shower chair. Further interview confirmed the shower chair did not have safety belts in place, no documentation of the use of the chair alarm and the resident was left unattended. Continued interview with the Care Plan Coordinator and the DON revealed the maintenance department did not have any documentation regarding the repair of the shower chair. Resident # 26 was admitted to the facility on July 28, 2003, with diagnoses of Essential Hypertension, Macular Degeneration, Cerebral Vascular Accident, Senile Dementia, Chronic Kidney Disease, and Osteoarthritis. Medical record review of the nursing assessment, dated April 26, 2012, revealed the resident had moderate impairment of cognitive skills and highly impaired vision. Medical record review of a Nursing Progress Note, dated August 4, 2011, at 2:41 p.m.,	N 424	Exhibit # 22 Resident # 21 After being informed by surveyor that CNA #12 had transported Resident # 21 from shower room, in a Hoyer lift, with the wrong sling, the DON conducted a teachable moment with CNA #12 on 5/14/12 and other staff working that day teaching that residents must not be transported down the hallway when residents are in the Hoyer lift. The Hoyer lift policy was reviewed with all staff working on the 7-3 and 3-11 shift by the DON on 5/16/12. All other licensed staff were then inserviced between 5/27/12-5/30/12. Exhibit # 23 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each	5/29/12

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N 424	Continued From page 13 revealed "...res (resident) fell out of bed landed on the floor L (left) side ...hematoma forehead...skin tear left thumb...transfer to hospital..." Review of facility documentation, dated August 4, 2011, at 2:15 p.m., revealed "...investigation revealed faulty side rail...Update: repair side rail immediately...8/4/11 side rail repaired..." Observation on May 15, 2012, at 11:00 a.m., in the dining hall, revealed the resident sitting in a Geri-chair asleep and with a clip alarm in use. Interview with Director of Nursing (DON) and the Care Plan Coordinator, on May 15, 2012, at 12:30 p.m., in the nurse's station, confirmed the faulty side rail caused the resident to fall on August 4, 2011. Further interview with the Care Plan Coordinator confirmed the facility failed to investigate the cause of the faulty side rail, what was fixed on the side rail or a descriptive assessment of the incident. C/O #27230 #27636	N 424	tag cited. Inservices given from 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI.	5/29/12
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on review of the Performance Improvement Committee attendance records, facility investigation reviews, facility policy	N 601	All residents received a Side Rail Assessment by a licensed nurse to determine appropriate use of side rails and restraints on those residents identified as being restrained by the use of side rails, Geri chairs, merry-walkers or specialized wheelchairs. They received a pre-restraint assessment and an informed consent was obtained. This process was begun on 5/15/12 and was completed on 5/29/12 with	

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	TN7201	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/14/2012

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N424		W424	Medical Director and DON approval. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 9 The following policies or procedures have been changed by the DON and approved by Medical Director and QA Committee on 5/27/12 to address these deficiencies and practices -Use of Restraints Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding	5/29/12

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N424		N424	-Behavior Assessment and Monitoring -Side rail Assessment on Admission and Quarterly Abuse Investigation sident Rights Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10 Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints ie Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management	5/29/12

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N424		N424	Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to	5/29/12

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N 424	Continued From page 13 revealed "...res (resident) fell out of bed landed on the floor L (left) side ...hematoma forehead...skin tear left thumb...transfer to hospital..." Review of facility documentation, dated August 4, 2011, at 2:15 p.m., revealed "...investigation revealed faulty side rail...Update: repair side rail immediately...8/4/11 side rail repaired..." Observation on May 15, 2012, at 11:00 a.m., in the dining hall, revealed the resident sitting in a Geri-chair asleep and with a clip alarm in use. Interview with Director of Nursing (DON) and the Care Plan Coordinator, on May 15, 2012, at 12:30 p.m., in the nurse's station, confirmed the faulty side rail caused the resident to fall on August 4, 2011. Further interview with the Care Plan Coordinator confirmed the facility failed to investigate the cause of the faulty side rail, what was fixed on the side rail or a descriptive assessment of the incident. C/O #27230 #27636	N 424		5/29/12
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on review of the Performance Improvement Committee attendance records, facility investigation reviews, facility policy	N 601	**F520 483.75 (o)(i)** **QA Committee Members/Meet Quarterly/ Plan** 1) The Quality Assurance Plan was reviewed and revised by the DON and Healthcare Consultant on 5/28/12. This revised plan, Quality	

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N 601	Continued From page 14 reviews, observations, and interviews the facility failed to ensure the Performance Improvement Committee identified resident's safety, falls, behavior management care planning, mental health rehabilitative services, abuse, and injuries of unknown origin as potential areas for quality improvement. The findings included: Review of facility investigations related to behaviors, resident to resident abuse, falls, and injuries of unknown origin revealed the facility had not utilized the data from the investigations, to track, trend, and address resident safety concerns (both individually and globally), or to use the data gained in formulating strategies to ensure resident safety for all residents residing in the facility. Interview with the Administrator May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed resident to resident abuse had occurred on more than one occasion. Continued interview revealed the facility did/does not have a behavior management plan or policy for a population of residents with high incidences of behavioral issues. Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed that no behavior management plan had been developed or utilized by the facility and the interventions in place were not adequate to ensure resident safety. The DON further confirmed that resident falls had not been recently addressed as a Performance Review issue. Interview with the Medical Director (MD), by	N 601	Assessment/Performance Improvement Plan was presented at the 5/29/12 QA Committee for approval by members. Exhibit # 25 A revised QA standing agenda was developed by the Healthcare Consultant to ensure quality issues are addressed and standing reports are reviewed quarterly for any issues with resident care. This standing agenda was approved 5/29/12 by the QA Committee. Exhibit # 26 Trending Reports were developed by Health Care Consultant to use for reporting incidents and including fall, abuse, medication errors, performance indicators,	5/29/12

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N 601	Continued From page 15 phone on May 14, 2012, at 2:17 p.m., revealed the MD is a Performance Improvement Committee member and attends quarterly meetings. The MD makes the decisions regarding psychiatric and other health related consultations for the residents. The MD denied remembering the incidents of resident to resident abuse or specific concerns related to resident safety. The Medical Director confirmed there was/is no specific behavior management policy employed by the facility. C/O 272636 #27230 #27265 #28092	N 601	infection control, and wound reports. This was completed on 05/29/2012 to be used at the next QI meeting. . Exhibit # 14	5/29/12
N 619	1200-8-6-.06(2)(d)7. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 7. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control. This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety, ensure residents were free from abuse, and ensure that residents with mental illness/behaviors were provided psychiatric services. The findings included:	N 619	2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI.	

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N 619	Continued From page 16 Telephone interview with the Medical Director (MD) on May 14, 2012, 2:17 p.m., revealed the MD attended the Performance Improvement Committee Meetings; was involved in implementation of facility policies and procedures related to safety or abuse; and there was no system in place to identify abuse, safety, and no behavior management program. Continued interview revealed the MD had not been aware of the facility's intervention of seclusion for resident #1's behaviors. The MD stated "...it would be an appropriate intervention for a resident cursing staff..." c/o #27636 #27230 #27265 #28092	N 619	**F 501 483.75 (2) Responsibilities of Medical Director** 1) Upon receipt of the 2567 Deficiency Report on 5/21/12 identifying immediate jeopardy for F 501 tag, the Medical Director was notified by the DON and the full Survey report was reviewed in-depth with Medical Director on 5/27/12.	5/29/12
N 643	1200-8-6-.06(3)(i) Basic Services (3) Infection Control. (i) The facility shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility; 2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications; 3. Education of all direct care personnel about the following: (i) Flu vaccination, (ii) Non-vaccine control measures, and	N 643	The Abuse Investigation policies, i.e. Reporting Abuse To Facility Management; Resident To Resident Altercation; Abuse Investigations; Behavior Assessment and Monitoring have been reviewed and revised on 5/27/2012 by the DON and approved by the Medical Director, Administrator and QA Committee on 5/27/12.	

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N619		N619	Exhibit # 24 The Abuse Investigation policy was inserviced with the Administrator, DON and Medical Director on 5/27/12 by the Healthcare Consultant emphasizing the importance of recording abuse allegation, investigating and reporting in a timely manner. The DON implemented a Behavior Management and Monitoring Program effective following approval by the Medical Director on 5/27/12 and QA Committee. All residents admitted with a history of impaired cognition, problematic behavior, or mental illness will have a consultation with a Geropsych Practitioner. This was addressed in the revised Behavior Assessment and Monitoring policy. This policy was reviewed and approved by the Medical Director and QA Committee on 5/27/12.	5/29/12

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N619		N619	Exhibit # 10 On 5/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address residents identified as having problematic behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geriopsych Practitioner Consult. This was addressed in the revised Behavior Assessment and	5/29/12

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N419		N419	Monitoring Policy. Policies were approved by Medical Director and QA Committee on 5/27/12. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. In-services were conducted on revised Behavior Management Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues that address residents not responding satisfactorily to treatments. These in-	5/29/12

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N619		N619	services were conducted on 5/28/12 & 5/29/12 by DON and RN/BSN. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The Administrator and DON reviEwed the Geropsych contact to ensure every other week visits could be provided to address residents with impaired cognition, problematic behavior or mental illness. This was confirmed on 5/18/12 by the Administrator.	5/29/12

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N619		N619	Investigation Form has possible Preventative Measures and suggested interventions that can aid licensed staff with implementing appropriate interventions. Also Fall Prevention and Potential Interventions and Strategies for Reducing the Risk for Falls were posted at the Nursing Station as a resource for selection of interventions if a fall occurs. This was done 5/29/12 by DON. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary,	5/29/12

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N619		N419	Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The newly created falls checklist provides the notification as a reminder to the staff to PT of falls. The Falls Prevention and Potential Interventions was placed at nurses on 5/28/12 and inserviced to nurses and others, 5/28/12-5/30/12 by DON and RN/BSN. The DON is responsible for the overall Falls Prevention Program, effective 5/29/2012. Exhibit # 21	5/29/12

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N619		N619	The Accident and Incidents Clinical Protocol policy for conducting Neuro checks following incidents where residents may have suffered head injury during the fall or an un-witnessed fall, was revised to call the Physician and obtain orders for frequency of Neuro checks. All residents experiencing falls will be monitored for 72 hours including Neuro checks as ordered by physician. DON or designee will monitor this process effective 5/16/12. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are	5/29/12

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N619		N619	Use of Restraints Behavior Assessment and Monitoring Side rail Evaluation on Admission and Quarterly Abuse Investigation/Seclusion Resident Rights/ Guidelines for all Nursing Procedures Accident and Supervision Exhibit # 10 On 5/29/12 Medical Director attended QA Committee to approve any policies or process changes that needed to be addressed. He was also available for any residents' issues that nurses and office may have had or orders needing signatures.	5/29/12

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N619		N619	On 5/27/12 the Medical Director made rounds, assessed and evaluated all residents with psychoactive medications or residents with behavior diagnoses. This evaluation was also documented in the Medical Record 5/27/12.	5/29/12

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N 761	Continued From page 18 (f) A minimum of three (3) days supply of food shall be on hand. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure a method to determine three day food supply. The findings included: Observation of the facility's dry food storage areas, coolers, and freezers on May 14, 2012, at 10:00 a.m., in the dietary department, revealed no special area set aside for an emergency supply per the Dietary Manager. Interview with the Dietary Manager on May 14, 2012, at 10:05 a.m., in the dietary department, confirmed the facility had no formula or method for calculating the amount of food required for the three day emergency supply and was not sure if there was enough food stored to meet the three day emergency menu.	N 761	**F223 483.13(b), 483.13 (c) (l) (i) Free Form** **Abuse / Involuntary Seclusion** 1) After being informed of the facility's failure to protect residents from abuse the following was put in place: Resident #1 - Changed resident's Care Plan effective 05/16/2012: 1. Deleted the approaches for his disruptive behavior that allowed resident to be placed in room with door closed with wheelchair disengaged, power cord removed from chair 2. Changed resident's 10:30 p.m. bedtime to allow him to determine his own bed time. All residents are permitted to go to bed at their choice of time effective 05/16/2012 by MDS Coordinator. Exhibit # 1 On 05/16/2012 the changes to resident # 1's Care Plan was	5/24/12
N1207	1200-8-6-.12(1)(g) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse.	N1207		

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N1207	Continued From page 19 Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to prevent abuse for four (#1, #2, #11, and #16) residents of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the nursing assessment dated March 15, 2012, revealed the resident had intact cognitive skills and no memory impairment; had no mood symptoms; required total assistance with activities of daily living (ADL); had impairment of upper and lower extremities; and used an electric wheelchair for mobility. Medical record review of the Care Plan dated March 15, 2012, revealed "...if res (resident) continues to curse...escorted or told to go to room for a 10 min (minute) cool down period...res not allowed to curse outside...room if res is not cooperative escort to room and disengage (turning off the source of electric power resulted in resident being unable to propel self) W/C (wheelchair) for 10-15 min...ensure safety and leave the room..." Medical record review of a nurse's note dated	N1207	verbally communicated to the nursing staff working on the 6 a.m. – 2 p.m., 2 – 10 p.m., and 10 p.m. – 6 a.m. shifts by the DON & MDS Coordinator and all subsequent shifts until the written revised care plan was completed later on that day, 05/16/2012. On 05/16/2012, the Administrator conducted a late investigation regarding resident # 1's allegation that employee's husband blocked him in his room and touched his arm. -5/27/12-Inservice given by Administrator to employees' spouse. -Witness statement was added to the abuse investigation form. A one on one in-service was given to the employee's spouse by the Administrator on 5/17/12. -Employee's spouse attended an in-service on abuse and neglect on 5/27/12. -On 5/29/12, the DON	5/29/12

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N1207	Continued From page 20 March 19, 2012, at 10:00 a.m., revealed "... (Resident #1) having a seizure..." Medical record review of a nurse's note dated March 19, 2012, at 10:44 a.m., revealed "...Doctor notified of possible seizure..." Review of a written statement by Certified Nurse Aide (CNA) #5 dated May 25, 2011, revealed "...spoke up and informed...(Resident #1) would be staying in bed for 15 min which is in...care plan punishment for cussing..." Review of a written statement by Licensed Practical Nurse (LPN) #1 dated June 24, 2011, revealed "...told (Resident #1)...would disengage...chair...disengaged...chair...pushed to...room and door left cracked for 15 minutes per care plan..." Review of a written statement by (CNA) #1 dated June 24, 2011, revealed "...the nurse was pushing...(Resident #1's) wheelchair that had been disengaged...to...room..." Review of a typed statement and signed by CNA #2 dated June 24, 2011, at 2:45 p.m., revealed "...power cord was taken from (Resident #1's)...power chair...was left in room for awhile...cooled down and was allowed to come out of...room..." Review of a written statement by CNA #3 dated June 24, 2011, revealed " ...nurse stated the other resident took priority...(Resident #1) became irate cursing...nurse told...to stop...continued resulting in wheelchair being disengaged...taken to...room...after allotted time was let out..."	N1207	investigated an allegation of abuse, using the new forms approved on 5/27/12, including witness statements and documented interviews. Exhibit # 35 On 05/16/2012 the Administrator conducted a late investigation regarding resident #1's allegation of an employee's spouse making threatening remarks to him. Employee no longer employed. Late investigation revised and a witness statement added. Exhibit #3-revised On 5/27/12, DON completed an allegation of abuse utilizing the new process for complaint investigations which included verbal and	5/29/12

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N1207	Continued From page 21 Review of a written statement by CNA #4 dated August 31, 2011, revealed "...(Resident #1) cussing the nurse...you don't want to get a shot and be in your room do you..." Medical record review of a nurse's note dated September 20, 2011, at 5:25 a.m., revealed "...Pt (patient) upset started cussing...(Resident #1's) W/C disengaged due to behavior..." Medical record review of a nurse's note dated September 20, 2011, at 7:04 a.m., revealed "...CNA let...know...was talking about (CNA)... (Resident #1) became defensive and started arguing again...escorted back to room..." Medical record review of a nurse's note dated October 19, 2011, at 11:40 p.m., revealed "(Resident #1) continues to speak loudly outside of room...asked...to go to room...refused...didn't have to...disengaged chair...pushed...to room ...saying...were assaulting...told...needed to be quiet...disregarded all instructions..." Medical record review of a nurse's note dated October 20, 2011, at 12:15 a.m., revealed "(Resident #1) yelling and cursing from room ...W/C remains off to attempt to keep others asleep ..." Medical record review of a nurse's note dated October 20, 2011, at 3:00 a.m., revealed "...continuing to keep...(Resident #1) safe and in...room to minimize disturbances to other residents..." Medical record review of a nurse's note dated October 20, 2011, at 3:30 a.m., revealed "... (Resident #1) in room to maintain...safety and have facility as quiet as possible..."	N1207	written employee and resident statements. Exhibit #35 On 05/19/2012, the Administrator conducted an investigation regarding the housekeeping supervisor's comment about resident # 1 looking in a mirror and seeing a monkey. Corrective action was noted on the investigation. One on one in-service to Housekeeping Supervisor 5/19/2012 by the Administrator. Exhibit # 4 The Abuse Investigation Policy & Restraint Management Policy was reviewed and revised by the DON and Health Care Consultant on 05/28/2012 and these policies were reviewed by the Health Care consultant with the DON, Administrator and Medical Director emphasizing the climination of the use of	5/29/12

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N1207	Continued From page 22 Medical record review of a nurse's note dated October 20, 2011, at 4:45 a.m., revealed "...reminded(Resident #1)...care plan to go to bed at 10:30 p.m...can do what...want...continuing to keep resident safe in...room and out of hallways..." Medical record review of a nurse's note dated October 20, 2011, at 6:20 a.m., revealed "...(Resident #1) still in...chair in...room..." Medical record review of a nurse's note dated October 20, 2011, at 10:48 a.m., revealed "...resident (#1) sitting in chair asleep..." Medical record review of a nurse's note dated October 20, 2011, at 12:00 p.m. (noon), revealed "...(Resident #1's) W/C still disengaged...C/O (complains of) not being taken care of...did want to lay down which according to care plan is on third shift...been primarily sleeping in chair all morning..." Observation and interview on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in the electric wheelchair; was alert and oriented. Interview with the resident revealed, "I have a bedtime at 10:30...I don't always want to go to bed at 10:30. They disengage my wheelchair sometimes...I don't want them to do that...I want that off my care plan. They sometimes block my wheelchair...I don't like that. The Director of Nursing's (DON) husband blocked me in and touched my arm...I don't want him in my room...he threatened me." Continued interview with the resident revealed "...two other employee's husbands came to the facility and threatened the resident; the staff make me eat last; when left in the wheelchair	N1207	seclusion, reporting abuse, investigation of abuse, and of using the Resident Abuse Investigation Report Form. Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12- 5/30/12. Staff not in attendance will no be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. Exhibit # 5 <u>Resident # 2 & # 3</u> The DON implemented a Behavior Assessment and Monitoring program effective following approval by the	5/29/12

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N1207	Continued From page 23 can't use the call light; and is limited to thirty minutes for baths." Interview with CNA #9 (day shift supervisor) on May 7, 2012, in the front lobby, confirmed the resident curses the staff frequently and the staff are instructed to disengage the resident's electric wheelchair, place the resident in the resident's room, and shut the door if the resident starts yelling. Interview with housekeeping supervisor on May 8, 2012, at 10:40 a.m., in the physical therapy room, confirmed the housekeeping supervisor did ask the resident, more than once, while holding a mirror "...when you look in a mirror do you see a monkey?" Further interview at this time with the housekeeping supervisor confirmed the resident reported to the housekeeping supervisor that the DON's husband threatened (not defined) the resident and the housekeeping supervisor reported it to the Nursing Home Administrator (NHA). (Report dates unknown and not documented.) Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator office, confirmed the housekeeping supervisor had asked the resident do you see a monkey when you look in the mirror; the staff disengaged the resident's electric wheelchair when the resident cursed; and the electric wheelchair disengagement was on the care plan. Continued interview at this time confirmed the Administrator was aware of two employee's husbands speaking to the resident, about the resident's behaviors; and the alleged abuse had not been investigated. Further interview at this time confirmed the NHA was unaware of the resident's right related to seclusion and no allegations of abuse had been	N1207	Medical Director on 05/27/2012 and the QA committee on 05/27/2012. All residents admitted with a history of impaired cognition problematic behavior, or mental illness will have a consultation with a Geriopsych practitioner. This was addressed in the revised Behavior Assessment & Monitoring policy. This policy was reviewed & approved by the Medical Director and QA committee on 05/27/2012. Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will	5/29/12

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N1207	Continued From page 24 investigated since December 23, 2010. Interview with the DON on May 8, 2012, at 12:25 p.m., in the front office, confirmed the alleged abuse by the DON's spouse had not been reported due to the DON had been present. Continued interview at this time revealed the DON could not deny or confirm if the spouse touched the resident. Further interview at this time with the DON confirmed the DON had been aware that two other employee's spouses had spoken with the resident regarding the cursing; unaware of date; and had not reported or investigated the alleged abuse. Telephone interview with CNA #6 on May 8, 2012, at 1:55 p.m., confirmed the resident curses staff frequently; instructed by DON per the care plan to place the resident in the resident's room; disengage the electric wheelchair; check every fifteen minutes; the resident was to go to bed at 10:30 p.m.; and if the resident refuses to go to bed leave the resident up until first round was completed. (First round refers to the time it takes for all other residents to be checked, cleaned, or put to bed. The exact amount of time for this to occur varies.) Interview with the DON on May 8, 2012, at 2:35 p.m., in the front office, confirmed the resident curses the staff frequently; care plan intervention was to place the resident in the resident's room; disengage the electric wheelchair; check the resident every ten to fifteen minutes; close the door if the resident yells; the resident was unable to use the call light while up in the electric wheelchair; the resident had no means to call the staff; and has a history of seizure activity. Interview with LPN #8 on May 8, 2012, at 2:55		oversee inservices and report to QA/PI. Exhibit # 6 All residents admitted to the facility will have a Social Services Assessment / History according to facility policy. Administrator reviewed with the Social Services Coordinator on 05/17/2012. A one on one in-service was conducted with current Social Service Coordinator on 5/17/12 by the administrator. Exhibit # 7 Resident # 11 On 05/16/12 the DON began the process for counseling LPN #3 concerning her approach to Resident #11 for inappropriate nursing actions related to cleaning up feces from floor. Employee resigned May 17, 2012 before actual counseling	5/29/12

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N1207	Continued From page 25 p.m., at the nurse's station, confirmed the resident curses the staff frequently; the CNA had been instructed to "...place the resident in the resident's room when cursing; disengage the electric wheelchair; thirty minutes at most; shut the door if the resident starts yelling..." and the resident was unable to use the call light while up in the electric wheelchair. Interview with Registered Nurse #1 on May 8, 2012, at 3:00 p.m., at the nurse's station, confirmed the resident curses the staff frequently; instructed to leave the resident in the resident's room; shut the door if the resident starts yelling; and disengage the electric wheelchair. Telephone interview with the DON's spouse on May 9, 2012, at 8:45 a.m., confirmed the spouse came to the facility March 6, 2012, heard the resident cursing the DON and went to the doorway of resident #1. Further interview at this time confirmed the spouse informed the resident not to use "that" language with the female staff; the spouse placed the hands on the electric wheelchair of the resident; and the resident did not want to talk to the spouse. Telephone interview with CNA #10 on May 14, 2012, at 3:25 p.m., revealed the CNA had been on the phone with the facility in May 2011; resident #1 cursed the CNA; the CNA's spouse had been aware of the resident's cursing; the CNA's spouse went to the facility "spoke" to the resident about cursing the CNA. Further interview at this time revealed facility staff witnessed the spouse talking with the resident. Continued interview at this time revealed the CNA informed the Administrator and DON and unaware if other staff reported the alleged verbal abuse.	N1207	was done. This incident was reported to the Board of Nursing by DON on 05/29/2012. Exhibit # 8 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on – Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. Inservices were given 5/27/1-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI.	5/29/12

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N1207	Continued From page 26 Interview with the DON on May 14, 2012, at 9:45 a.m., in the DON office, revealed on October 19, 2011, around midnight the resident had been cursing the staff; the resident refused to quit cursing; the resident's electric wheelchair had been disengaged; the resident had been placed in the resident's room without a call light; the resident had not been able to call for assistance except by yelling; the resident had a known history of seizure activity; the resident's electric wheelchair had been left disengaged for twelve hours; the resident requested to go to bed at the end of the twelve hours and had been informed bedtime was on third shift. Telephone interview with the Medical Director (MD) on May 14, 2012, at 2:30 p.m., revealed placing the resident with a known seizure disorder and known seizure activity in the resident's room, disengaging the electric wheel chair and without access to the call light would be an appropriate intervention for the resident's behavior of cursing the staff. Further interview confirmed the MD stated he had no expectations of the frequency the resident should be checked on while in seclusion. Telephone interview with Nurse Practitioner (NP) #1 on May 15, 2012, at 3:12 p.m., revealed placing the resident in the resident's room, disengaging the electric wheelchair, without a call light is seclusion, and in the NP #1's professional opinion was not an appropriate intervention for behaviors of cursing the staff. Resident # 2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia.	N1207	The following policies or procedures have been changed to address this deficiency practice: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Evaluation on Admission and Quarterly -Abuse Investigation -Resident Rights Guidelines for all nursing procedures RN, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10	5/29/12

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N1207	Continued From page 27 Medical record review of the nursing assessments dated November 4, 2010, (prior to incident) and February 23, 2012, (current assessment) revealed the resident was severely cognitively impaired, has a history of wandering, and required limited staff assistance with ADLs (Activities of Daily Living). Medical record review revealed resident #2 had a history of falls and wandering behaviors. The medical record review included review of a facility investigation dated January 2, 2011, sustained a skin tear from a fall. No details of the fall or new interventions were documented. Medical record review of the care plan dated February 21, 2012, revealed an entry dated January 12, 2011, revealed, "...resident tried to crawl in bed with another resident (#1) and fell..." Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed, "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Medical record review of a Nurse's Note dated February 29, 2012, at 4:00 p.m.revealed, "...Resident (#2) was in geri-chair and managed to tip it over on it's side with resident still in it..." Continued review of the February 29, 2012, Nurse's Notes revealed an entry at 4:20 p.m., documenting, " Resident again tipped over in geri-chair..." The resident was assessed and assisted back to the geri-chair. No new interventions to prevent the resident from tipping over in the geri-chair were documented. Medical record review of a facility investigation	N1207	Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 -Resident Rights and Dignity -Restraints i.e.: Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator. Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 11	5/29/12

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N1207	Continued From page 28 dated March 1, 2012, revealed an investigation of the 4:20 p.m. fall, noting the resident sustained a "...skin tear to the left elbow and a contusion to te left side of head..." The intervention was to "...ambulate the resident for 15 min (minutes) Q (every) shift." Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed the facility failed to ensure resident #2's safety. Resident #11 was admitted to the facility on August 22, 2011, with diagnoses including Seizure Disorder, Dentatorubral-Pallidoluysian Atrophy, and Hypertension. Medical record review of the nursing assessment dated September 1, 2011, and March 1, 2012, revealed the resident had severe impairment in cognitive skills. Medical record review of a Nursing Progress Note dated January 6, 2012, revealed "...3:30AM Resident sitting on edge of bed looking at a pile of feces that...had just purposely pooped in the middle of...room. Over this past week...has done this and finger painted with feces. CNAs (certified nursing assistants) relay that this resident is having increased behaviors of this sort. Sitting in hallway, nearly naked; in and out of resident's room nearly naked, does not redirect well. When told to clean feces from the floor (resident) reached down with bare hands to reclaim it. This after being told to use toilet tissue...has been awake the entire shift..." Interview on May 9, 2012, at 9:15 a.m., in the therapy room, regarding the incident on January 6, 2012, with the Director of Nursing, stated	N1207	On 5/27/12 The Medical Director evaluated and assessed all residents with psychoactive medications or residents with behavior diagnoses. The evaluation was also documented in the Medical Record on 5/27/12. ADON/DON/ MDS Coordinator assessed all other residents for signs of abuse, complaints of abuse, and any behaviors needing a consultation of the physician or Geriopsych Consultant. This assessment began on 5/15/2012, completed on 5/27/12. All residents care plans were reviewed by MDS Coordinator for appropriate behavior interventions. This process began on 5/15/2012, completed on 5/29/12.	5/29/12

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N1207	Continued From page 29 "That's terrible" and confirmed the intervention was not appropriate for this behavior. Interview on May 14, 2012, at 1:30 p.m. with Licensed Practical Nurse #3, (incident on January 6, 2012 documented by this nurse) by phone, confirmed the resident was asked to clean up the bowel movement from the floor. Continued interview with Licensed Practical Nurse #3 stated, "(resident) was supposed to correct it...if (resident) did something unreasonable." Interview on May 14, 2012, at 3:25 p.m., in the hall, with CNA (certified nursing assistant) #17, confirmed resident has had finger painting with feces and will try to redirect when this occurs. Interview on May 14, 2012, at 3:40 p.m., in the therapy room, with Social Services, confirmed the incident on January 6, 2012, is abuse. Resident #16 was admitted to the facility on December 20, 1994, with diagnoses including Cerebral Palsy, Seizure Disorder, and Encephalopathy. Medical record review of the nursing assessment dated March 15, 2012, revealed the resident was moderately impaired for decision making, is totally dependent for all activities of daily living, and eating. Medical record review of the Interdisciplinary Care Plan last review June 16, 2011, revealed "...difficulty swallowing at times...give verbal encouragement to finish meal...feed at all meals..." Medical record review of a Nurse's note dated February 19, 2012, at 4:45 p.m., revealed	N1207		5/29/12

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N1207	Continued From page 30 "...Observed resident's (family member)...using excessive force while attempting to feed...displaying anger and intolerance...resident was refusing to eat..." Interview with the Care Plan Coordinator on May 14, 2012, at 11:00 a.m., in the DON's office, confirmed the Care Plan Coordinator witnessed resident #16's family member using force and displaying anger on February 19, 2012, and reported it to the Administrator. Further interview at this time revealed the family member was forcing the spoon in the resident's mouth and the family member's tone was angry. Interview with the Administrator on May 14, 2012, at 1:40 p.m., in the Administrator's office, confirmed the Administrator had knowledge of the alleged abuse of resident #16; called the family member of the resident, and no investigation or documentation of the incident had been completed. C/O #27265 #27230 #28092	N1207		5/29/12

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N1207	Continued From page 23 can't use the call light; and is limited to thirty minutes for baths." Interview with CNA #9 (day shift supervisor) on May 7, 2012, in the front lobby, confirmed the resident curses the staff frequently and the staff are instructed to disengage the resident's electric wheelchair, place the resident in the resident's room, and shut the door if the resident starts yelling. Interview with housekeeping supervisor on May 8, 2012, at 10:40 a.m., in the physical therapy room, confirmed the housekeeping supervisor did ask the resident, more than once, while holding a mirror "...when you look in a mirror do you see a monkey?" Further interview at this time with the housekeeping supervisor confirmed the resident reported to the housekeeping supervisor that the DON's husband threatened (not defined) the resident and the housekeeping supervisor reported it to the Nursing Home Administrator (NHA). (Report dates unknown and not documented.) Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator office, confirmed the housekeeping supervisor had asked the resident do you see a monkey when you look in the mirror; the staff disengaged the resident's electric wheelchair when the resident cursed; and the electric wheelchair disengagement was on the care plan. Continued interview at this time confirmed the Administrator was aware of two employee's husbands speaking to the resident, about the resident's behaviors; and the alleged abuse had not been investigated. Further interview at this time confirmed the NHA was unaware of the resident's right related to seclusion and no allegations of abuse had been	N1207		5/29/12

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N1207	Continued From page 24 investigated since December 23, 2010. Interview with the DON on May 8, 2012, at 12:25 p.m., in the front office, confirmed the alleged abuse by the DON's spouse had not been reported due to the DON had been present. Continued interview at this time revealed the DON could not deny or confirm if the spouse touched the resident. Further interview at this time with the DON confirmed the DON had been aware that two other employee's spouses had spoken with the resident regarding the cursing; unaware of date; and had not reported or investigated the alleged abuse. Telephone interview with CNA #6 on May 8, 2012, at 1:55 p.m., confirmed the resident curses staff frequently; instructed by DON per the care plan to place the resident in the resident's room; disengage the electric wheelchair; check every fifteen minutes; the resident was to go to bed at 10:30 p.m.; and if the resident refuses to go to bed leave the resident up until first round was completed. (First round refers to the time it takes for all other residents to be checked, cleaned, or put to bed. The exact amount of time for this to occur varies.) Interview with the DON on May 8, 2012, at 2:35 p.m., in the front office, confirmed the resident curses the staff frequently; care plan intervention was to place the resident in the resident's room; disengage the electric wheelchair; check the resident every ten to fifteen minutes; close the door if the resident yells; the resident was unable to use the call light while up in the electric wheelchair; the resident had no means to call the staff; and has a history of seizure activity. Interview with LPN #8 on May 8, 2012, at 2:55	N1207		5/29/12

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N1207	Continued From page 25 p.m., at the nurse's station, confirmed the resident curses the staff frequently; the CNA had been instructed to "...place the resident in the resident's room when cursing; disengage the electric wheelchair; thirty minutes at most; shut the door if the resident starts yelling..." and the resident was unable to use the call light while up in the electric wheelchair. Interview with Registered Nurse #1 on May 8, 2012, at 3:00 p.m., at the nurse's station, confirmed the resident curses the staff frequently; instructed to leave the resident in the resident's room; shut the door if the resident starts yelling; and disengage the electric wheelchair. Telephone interview with the DON's spouse on May 9, 2012, at 8:45 a.m., confirmed the spouse came to the facility March 6, 2012, heard the resident cursing the DON and went to the doorway of resident #1. Further interview at this time confirmed the spouse informed the resident not to use "that" language with the female staff; the spouse placed the hands on the electric wheelchair of the resident; and the resident did not want to talk to the spouse. Telephone interview with CNA #10 on May 14, 2012, at 3:25 p.m., revealed the CNA had been on the phone with the facility in May 2011; resident #1 cursed the CNA; the CNA's spouse had been aware of the resident's cursing; the CNA's spouse went to the facility "spoke" to the resident about cursing the CNA. Further interview at this time revealed facility staff witnessed the spouse talking with the resident. Continued interview at this time revealed the CNA informed the Administrator and DON and unaware if other staff reported the alleged verbal abuse.	N1207		5/29/12

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	TN7201	A. BUILDING _____ B. WING _____	05/15/2012

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N1207	Continued From page 26 Interview with the DON on May 14, 2012, at 9:45 a.m., in the DON office, revealed on October 19, 2011, around midnight the resident had been cursing the staff; the resident refused to quit cursing; the resident's electric wheelchair had been disengaged; the resident had been placed in the resident's room without a call light; the resident had not been able to call for assistance except by yelling; the resident had a known history of seizure activity; the resident's electric wheelchair had been left disengaged for twelve hours; the resident requested to go to bed at the end of the twelve hours and had been informed bedtime was on third shift. Telephone interview with the Medical Director (MD) on May 14, 2012, at 2:30 p.m., revealed placing the resident with a known seizure disorder and known seizure activity in the resident's room, disengaging the electric wheel chair and without access to the call light would be an appropriate intervention for the resident's behavior of cursing the staff. Further interview confirmed the MD stated he had no expectations of the frequency the resident should be checked on while in seclusion. Telephone interview with Nurse Practitioner (NP) #1 on May 15, 2012, at 3:12 p.m., revealed placing the resident in the resident's room, disengaging the electric wheelchair, without a call light is seclusion, and in the NP #1's professional opinion was not an appropriate intervention for behaviors of cursing the staff. Resident # 2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia.	N1207		5/29/12

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N1207	Continued From page 27 Medical record review of the nursing assessments dated November 4, 2010, (prior to incident) and February 23, 2012, (current assessment) revealed the resident was severely cognitively impaired, has a history of wandering, and required limited staff assistance with ADLs (Activities of Daily Living). Medical record review revealed resident #2 had a history of falls and wandering behaviors. The medical record review included review of a facility investigation dated January 2, 2011, sustained a skin tear from a fall. No details of the fall or new interventions were documented. Medical record review of the care plan dated February 21, 2012, revealed an entry dated January 12, 2011, revealed, "...resident tried to crawl in bed with another resident (#1) and fell..." Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed, "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Medical record review of a Nurse's Note dated February 29, 2012, at 4:00 p.m.revealed, "...Resident (#2) was in geri-chair and managed to tip it over on it's side with resident still in it..." Continued review of the February 29, 2012, Nurse's Notes revealed an entry at 4:20 p.m., documenting, " Resident again tipped over in geri-chair..." The resident was assessed and assisted back to the geri-chair. No new interventions to prevent the resident from tipping over in the geri-chair were documented. Medical record review of a facility investigation	N1207		5/29/12

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N1207	Continued From page 28 dated March 1, 2012, revealed an investigation of the 4:20 p.m. fall, noting the resident sustained a "...skin tear to the left elbow and a contusion to te left side of head..." The intervention was to "...ambulate the resident for 15 min (minutes) Q (every) shift." Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed the facility failed to ensure resident #2's safety. Resident #11 was admitted to the facility on August 22, 2011, with diagnoses including Seizure Disorder, Dentatorubral-Pallidoluysian Atrophy, and Hypertension. Medical record review of the nursing assessment dated September 1, 2011, and March 1, 2012, revealed the resident had severe impairment in cognitive skills. Medical record review of a Nursing Progress Note dated January 6, 2012, revealed "...3:30AM Resident sitting on edge of bed looking at a pile of feces that...had just purposely pooped in the middle of...room. Over this past week...has done this and finger painted with feces. CNAs (certified nursing assistants) relay that this resident is having increased behaviors of this sort. Sitting in hallway, nearly naked; in and out of resident's room nearly naked, does not redirect well. When told to clean feces from the floor (resident) reached down with bare hands to reclaim it. This after being told to use toilet tissue...has been awake the entire shift..." Interview on May 9, 2012, at 9:15 a.m., in the therapy room, regarding the incident on January 6, 2012, with the Director of Nursing, stated	N1207		5/29/12

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N1207	Continued From page 29 "That's terrible" and confirmed the intervention was not appropriate for this behavior. Interview on May 14, 2012, at 1:30 p.m. with Licensed Practical Nurse #3, (incident on January 6, 2012 documented by this nurse) by phone, confirmed the resident was asked to clean up the bowel movement from the floor. Continued interview with Licensed Practical Nurse #3 stated, "(resident) was supposed to correct it...if (resident) did something unreasonable." Interview on May 14, 2012, at 3:25 p.m., in the hall, with CNA (certified nursing assistant) #17, confirmed resident has had finger painting with feces and will try to redirect when this occurs. Interview on May 14, 2012, at 3:40 p.m., in the therapy room, with Social Services, confirmed the incident on January 6, 2012, is abuse. Resident #16 was admitted to the facility on December 20, 1994, with diagnoses including Cerebral Palsy, Seizure Disorder, and Encephalopathy. Medical record review of the nursing assessment dated March 15, 2012, revealed the resident was moderately impaired for decision making, is totally dependent for all activities of daily living, and eating. Medical record review of the Interdisciplinary Care Plan last review June 16, 2011, revealed "...difficulty swallowing at times...give verbal encouragement to finish meal...feed at all meals..." Medical record review of a Nurse's note dated February 19, 2012, at 4:45 p.m., revealed	N1207		5/29/12

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N1207	Continued From page 30 "...Observed resident's (family member)...using excessive force while attempting to feed...displaying anger and intolerance...resident was refusing to eat..." Interview with the Care Plan Coordinator on May 14, 2012, at 11:00 a.m., in the DON's office, confirmed the Care Plan Coordinator witnessed resident #16's family member using force and displaying anger on February 19, 2012, and reported it to the Administrator. Further interview at this time revealed the family member was forcing the spoon in the resident's mouth and the family member's tone was angry. Interview with the Administrator on May 14, 2012, at 1:40 p.m., in the Administrator's office, confirmed the Administrator had knowledge of the alleged abuse of resident #16; called the family member of the resident, and no investigation or documentation of the incident had been completed. C/O #27265 #27230 #28092	N1207		5/29/12